# Health Maintenance Organizations

# Health Maintenance Organizations

# Introduction

**What Are My Choices?**

Your health plan options for 2004 are The State Health Plan (see Pages 3-41 for details), traditional Health Maintenance Organizations (HMO) plans, HMO with Point of Service (POS) options and the TRICARE Supplement plan (see Pages 59-63 for more information). The State Health Plan and the TRICARE Supplement are offered statewide; however, not all HMOs are available in all service areas. Active employees must live or work in an HMO's service area to enroll in its plan. Retirees, COBRA subscribers and survivors must live in an HMO's service area to enroll in its plan.

The following traditional HMOs and HMOs with POS options are available for 2004:

- Companion HMO
- Companion-CHOICES
- CIGNA HMO
- MUSC Options

**Traditional HMO**

A traditional HMO plan is one in which subscribers are required to see only providers within the HMO's network. If you receive care outside of this network, the HMO will not pay benefits for these services unless the care was preauthorized or deemed an emergency. You are required to choose a primary care physician (PCP) who coordinates all aspects of your healthcare. To receive benefits, you must receive a referral from your PCP before you can see a specialist.

**Point of Service (POS) Plan**

A POS plan is an HMO plan that allows you to selectively go to a provider inside or outside of its network. To receive the maximum level of benefits, care must be obtained within the HMO network and be authorized by the HMO. When you use out-of-network services, you are likely to have much higher out-of-pocket expenses in the form of deductibles and copayments.

| 2004 Health Plan Service Areas | | |
|---|---|---|
| **CODE** | **COUNTY** | **HMO CHOICES** |
| 1 | Anderson, Greenville, Oconee, Pickens | Companion-CHOICES, CIGNA HMO |
| 2 | Cherokee, Spartanburg, Union | Companion-CHOICES, CIGNA HMO |
| 3 | Chester, Lancaster, York | Companion HMO, CIGNA HMO |
| 4 | Abbeville, Greenwood, Laurens, McCormick, Saluda | Companion HMO |
| 5 | Fairfield, Kershaw, Lexington, Newberry, Richland | Companion HMO, CIGNA HMO |
| 6 | Aiken, Barnwell, Edgefield | Companion HMO |
| 7 | Allendale, Bamberg, Calhoun, Orangeburg | Companion HMO, CIGNA HMO |
| 8 | Clarendon, Lee, Sumter | Companion HMO, CIGNA HMO |
| 9 | Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg | Companion HMO, CIGNA HMO |
| 10 | Georgetown, Horry | Companion HMO, CIGNA HMO |
| 11 | Berkeley, Charleston, Colleton, Dorchester | Companion HMO, CIGNA HMO, MUSC Options |
| 12 | Beaufort, Hampton, Jasper | Companion HMO, CIGNA HMO |

**HMO Descriptions**

A brief description of each HMO is included in this guide. Please refer to the Premiums section beginning on Page 203 for HMO premiums and a comparison of benefits. For more information, active employees should contact their benefits administrator, the HMO or EIP. Retirees, COBRA subscribers and survivors should contact the HMO or EIP for additional information.

# Companion HMO and Companion-CHOICES

Companion HealthCare administers two of the HMO plans available. These plans are:

- Companion HMO, a traditional HMO plan, available in service areas 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12.
- Companion-CHOICES, a POS plan, available in service areas 1 and 2.

**Primary Care Physician**

Both plans use primary care physicians to manage your healthcare. At enrollment, you select your primary care physician (PCP) from Companion HealthCare's statewide network. That physician coordinates all healthcare services covered under your plan. When you need to see a specialist or other healthcare professional, your PCP will refer you to a network provider. You'll get an authorization stating what services are approved, and then Companion will cover those healthcare services according to your group's plan.

Each member of your family may select a different PCP. Women can go to a participating gynecologist for two visits each year without a referral from the primary care physician. Visits beyond this require approval. Women may also go to a participating obstetrician for prenatal care.

PCPs in the Companion network are available to you 24 hours a day, seven days a week. If your personal doctor isn't available, he arranges for another doctor to take care of you.

## In-Network Benefits

With Companion HMO you receive benefits for covered services **only** when you receive those services from participating physicians, hospitals and other healthcare providers. With the Companion-CHOICES plan you must use participating providers in order to receive the savings the network offers. There are advantages to using in-network doctors. These doctors will:

- File claims for covered expenses for you;
- Ask you to pay only the copayment and coinsurance amounts, if any, for covered expenses; and
- Accept the plan's payment as payment in full for covered expenses, minus the copayment or coinsurance, if any.

**Copayments**

Copayment amounts vary depending on the type of services you receive. Companion HMO does not have an annual deductible. Companion-CHOICES does not have an annual deductible when you use participating providers. The copayment amounts for participating doctor and hospital services for both plans are:

- $15 PCP per visit;
- $15 OB/GYN well woman exam (women may self-refer to a contracting gynecologist twice a year);
- $25 specialist per visit;
- $35 urgent care per visit;

- $200 per inpatient hospital admission;
- $75 outpatient services for the first three visits;
- $75 emergency room visit;
- $200 per admission for inpatient mental health and substance abuse care;
- $25 outpatient mental health and substance abuse visit.

**Coinsurance**

The amount of coinsurance you are responsible for is 10 percent for hospital and emergency services (in-network) under both HMO plans.

**Coinsurance Maximum**

Under both plans, once you have spent either $1,500 (individual coverage) or $3,000 (family coverage) out of your pocket in a year for in-network services, the plan will pay 100 percent of your medical costs for the remainder of the year. Copayments do not contribute to your out-of-pocket limit.

**Prescription Drugs**

The Companion plans also provide for your prescription medication needs. You **must** use a participating pharmacy (or mail service) when purchasing your medications. Benefits are not payable if you use a nonparticipating pharmacy. There is no annual copayment maximum for this benefit.
Copayments for up to a 31-day supply are:

- $7 for generics;
- $25 for preferred brands;
- $40 for nonpreferred brands;
- $75 specialty pharmaceuticals.

Mail-order service for up to 90-day supply is also available. The copayments are:

- $21 for generics;
- $75 for preferred brands;
- $120 for nonpreferred brands.

## Out-of-Network Benefits

**Companion HMO**

The only services you receive from out-of-network providers that this plan covers are those for emergency medical conditions. If you have a life- or limb-threatening illness or injury, please go to the nearest hospital or treatment center, whether or not it is in the network. You or a family member should tell your primary care physician and Companion HMO about the emergency as soon as possible. In order to have benefits, you must receive all other covered services from network physicians.

**Companion-CHOICES**

With Companion-CHOICES, you can enjoy the flexibility of visiting the doctors of your choice, even if they aren't in the network. Your out-of-pocket costs will be a little more, because you may have to pay higher copayments, deductibles and coinsurance. You also may have to file your own claims. Some services, such as coverage for preventive care services, routine health screenings, well-baby and well-child care, may not be covered if you go outside the network. Refer to your schedule of benefits for more information about covered services.

You may seek emergency care from out-of-network hospitals or doctors and still receive the in-network level of benefits. If you have a life- or limb-threatening illness or injury, go to the nearest hospital or treatment center, regardless of whether it is in the network. Remember to tell your primary care physician and Companion-CHOICES about the emergency as soon as possible.

Benefits obtained outside the Companion-CHOICES provider network are covered at 70 percent of allowable charges after you've met your annual deductible. The annual deductible is $500 per person.

The annual out-of-pocket maximum is $3,000 for individual coverage and $6,000 for family coverage. After the annual out-of-pocket maximum is met, Companion-CHOICES will pay 100 percent of allowable charges after the applicable copayment for covered medical benefits for the remainder of the year. Annual deductibles, copayments and charges above reasonable and customary do not contribute to your out-of-pocket maximums.

**Copayments**

The copayment amounts for hospital services out-of-network are:

- $250 per inpatient hospital admission;
- $125 outpatient services;
- $75 emergency room visit.

## Other Plan Features

The Companion plans also offer a variety of health management programs. Companion has worked with network physicians to develop programs that may help you make lifestyle changes that could improve your health. Best of all, these programs are offered either free of charge or for a small one-time fee. Program topics include healthy mom and baby, healthy hearts, diabetes control, weight management and smoking cessation. For more information on these programs, call the Health Management department at 800-327-3183, ext 45541. You can also visit the Web site at www.companionhealthcare.com. Other plan features include:

- Vision care. One exam for glasses per year (contact lens exam and fitting is extra); glasses from designated selection every two years or you can receive credit toward the purchase of contacts. You must use a participating provider.
- Natural Blue offers special savings on health and wellness products such as acupuncturists, massage therapists, laser vision correction, vitamins and herbal supplements, books and tapes.

**Claims**

When receiving in-network care, your PCP or other participating provider will file your claims for you. If you receive out-of-network emergency care, you may have to pay fees out of your pocket. For information on the claims process, call Companion's Member Services Department at 803-786-8476 in Columbia and 1-800-868-2528 outside the Columbia area.

**Appeals**

If you have a complaint, grievance or suggestion, Companion wants to know. Contact the Member Services department at 803-786-8476 in Columbia and 800-

868-2528 outside the Columbia area. Or write a letter, if you prefer. The address is:

Companion HealthCare
Member Services Department
P.O. Box 6170
Columbia, SC 29260-6170

You also can e-mail Companion HMO through the Web site at www.companionhealthcare.com.

If your complaint is regarding the quality of care you received, Companion will start a formal investigation through the quality management department. You must send all claims, questions or appeals within six months after you received the service.

If you have a question about an authorization, you must notify Companion within six months from the date authorization was approved or denied. If you do not contact Companion within six months, the decision will be considered final.

As a Companion member, you or your designated representative have access to internal and independent external organization review levels of appeal. The internal review is a one-level review that includes panel review.

For medical necessity appeals, actively practicing physicians of the same or similar specialty will review. Benefits appeals and provider appeals are eligible only for internal review. All member appeals are completed, including member notification of the decision, within 30 days of receipt by Companion.

If you are still dissatisfied after Companion HealthCare has reviewed their decision, you may request that Employee Insurance Program (EIP) review the matter by making a written request to EIP within 90 days of notice of their denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

If you need more information about the appeal process, please call Companion HealthCare Member Services at 800-868-2528 or 803-786-8476.

# CIGNA HMO

CIGNA HMO, a traditional HMO plan administered by CIGNA HealthCare, is available in the following service areas 1, 2, 3, 5, 7, 8, 9, 10, 11 and 12.

**Primary Care Physician**

With CIGNA HMO, your primary care physician (PCP), is your first and primary source of medical care. The PCP you choose coordinates your medical care, including checkups, referrals to specialists, lab and x-ray services and hospital admissions.

When you enroll in CIGNA HMO you choose a PCP for yourself and each covered dependent in your family. Each family member may choose a different PCP. Women may also select an OB/GYN in addition to their PCP. No referral is ever required to the OB/GYN. A PCP can be a family/general practitioner, internist or pediatrician. PCPs are available to you 24-hours-a-day, seven days a week. If your personal doctor isn't available, he arranges for another doctor to take care of you.

## In-Network Benefits

With CIGNA HMO you receive benefits for covered services **only** when you receive those services from participating physicians, hospitals and other healthcare providers. These in-network doctors will:

- File claims for covered expenses for you; and
- Ask you to pay only the copayment and coinsurance amounts, if any, for covered expenses.

**Copayments**

Copayment amounts vary depending on the type of services you receive. The CIGNA HMO plan has no annual deductible. Copayment amounts for doctor and hospital services are:

- $20 PCP visit;
- $40 OB/GYN;
- $40 specialist;
- $500 per inpatient hospital admission;
- $250 outpatient surgery and medical care;
- $100 emergency care;
- $500 per admission for inpatient mental health and substance abuse care;
- $40 outpatient mental health and substance abuse visit.

**Coinsurance**

The amount of coinsurance you are responsible for is 20 percent for hospital services (in-network).

**Coinsurance Maximum**

Once you have spent either $3,000* (individual coverage) or $6,000* (family coverage) out of your pocket in a year for in-network services, the plan will pay 100 percent of your covered medical costs for the remainder of the year. ***Inpatient and outpatient copayments and coinsurance count toward your out-of-pocket maximum, however, other copayments do not contribute to your out-of-pocket limit.**

**Prescription Drugs**

The CIGNA plan also provides coverage for your prescription drugs. With CIGNA HMO, you **must** use a participating pharmacy (or mail service) when purchasing your medications. Benefits are not payable if you use a nonparticipating pharmacy. There is no annual copayment maximum for this benefit.Copayments for up to a 30-day supply are:

- $10 for generics;
- $20 for preferred brands;
- $50 for nonpreferred brands.

CIGNA HMO offers an online prescription center (CIGNA TelDrug) that allows you to order prescriptions and refills for home delivery, review the covered drug list and check the status of a recent order 24 hours a day. The copayments for up to 90-day supply are:

- $20 for generics;
- $40 for preferred brands;
- $100 for nonpreferred brands.

## Out-of-Network Benefits

The only services you receive from out-of-network providers that this plan covers are those for emergency medical conditions. If you have a life- or limb-threatening illness or injury, please go to the nearest hospital or treatment center, whether or not it is in the network. We do ask that you or a family member tell your primary care physician and CIGNA HMO about the emergency as soon as possible. In order to have benefits, you must receive all other covered services from network physicians.

## Other Plan Features

Other special features of the CIGNA plans include:

- The CIGNA 24-Hour Health Information Line℠ that provides access to medical information, level of care counseling, an audio library of hundreds of topics and guidance to network providers.
- The Healthy Rewards program that includes special offers for discounts on health-related products and services.
- Vision care. Subscribers receive a $10 eye exam every two years. You must use a participating provider.
- Nationwide access to specially trained experts and nationally recognized facilities through the CIGNA LIFESOURCE Organ Transplant Network.

**Claims**

There's no paperwork for in-network care. Just show your CIGNA plan ID card and pay your copayment; your provider will complete and submit the paperwork. If you visit an out-of-network provider, you or your provider only need to file a paper claim. You will receive an Explanation of Benefits identifying the costs covered by your plan and the charges you must pay. For more information on the claims process, please contact CIGNA HealthCare at 800-244-6224.

**Appeals**

The following steps must be followed if you have a concern or appeal.

- Call or write CIGNA's Member Services Department and a representative will work with you to resolve your concern.
- If it is not resolved to your satisfaction, you may appeal the decision to CIGNA's Appeal Committee. This is called a Level One Appeal. You will receive a letter on the committee's decision within 30 calendar days.
- If you are still unhappy with the decision, you may have your appeal sent to the Grievance Committee. This is a Level Two Appeal. The Grievance Committee will notify you in writing of its decision within 30 calendar days.

If you are still dissatisfied after CIGNA HealthCare has reviewed its decision, you may request that EIP review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001). For more information on the appeals process, please contact CIGNA HealthCare at 800-244-6224, or write CIGNA HealthCare at P.O. Box 5200, Scranton, PA 18505.

# MUSC Options

**Introduction**

MUSC Options is a self-funded, POS plan that is administered by Companion HealthCare and Medco Health Solutions, Inc. Active, permanent, full-time state-covered entity employees, who live or work in service area 11 are eligible to enroll. The plan is also available to non-Medicare retirees, survivor and COBRA subscribers who live in this area.

**Primary Care Physician**

When you enroll in MUSC Options, you will need to select a primary care physician (PCP). Your PCP may be a physician that practices internal medicine, family practice or pediatrics. All medical services must be authorized in advance by your PCP and/or Companion HealthCare (the plan administrator) in order to receive in-network benefits. Each member of your family may select a different PCP.

**Referrals**

If you need to see a specialist, your PCP will refer you to a specialist who participates in the MUSC Options network. You may self-refer to a specialist; however, you receive the highest level of benefits when your PCP refers you.

**Copayments**

Copayment amounts vary depending on the type of services you receive. The copayment amounts for doctor and hospital services received within the MUSC Options provider network are:

- $15 PCP per visit;
- $15 OB/GYN well woman exam (two self-referred visits/year);
- $25 specialist per visit with referral;
- $45 specialist per visit without referral;
- $300 per inpatient hospital admission;
- $100 per outpatient hospital visit for major services (maximum of three copayments per year);
- $100 per emergency room visit.

## Prescription Drug Program

MUSC Options Prescription Drug Program, administered by Medco Health Solutions, Inc., is both easy and convenient to use. With this program, you simply show your MUSC Options identification (ID) card when you purchase your prescription drugs from a participating pharmacy and pay the following copayments for up to a 31-day supply:

- $10 for generics drugs;
- $25 for preferred brand medications;
- $40 for nonpreferred brand medications.

Mail-order medications for up to a 90-day supply are also covered. Copayments for mail-order medications are

- $15 for generics drugs;
- $50 for preferred brand medications;
- $80 for nonpreferred brand medications.

**"Pay-the-Difference"**

A "pay-the-difference" policy has been implemented. This means if a generic drug is available, and you purchase the brand name medication instead, the benefit will be limited to the cost of the generic medication and you will be responsible for the price difference.

MUSC Options participates in the Select Rx Network, Medco Health's pharmacy network. For a list of participating providers, go to www.medcohealth.com. Remember, you **must** use a participating pharmacy or mail service and you **must** show your ID card when purchasing your medications. **Benefits are not payable if you use a nonparticipating pharmacy.**

**Vision Care**

Routine Vision Care plan pays up to $75 for routine eye exam per benefit period and up to $75 for eye wear once every other benefit period. You may use any licensed vision care provider, then file a claim for reimbursement.

## Out-Of-Network Benefits

Benefits obtained outside the MUSC Options provider network are covered at 60 percent of allowable charges after an annual deductible. The annual deductible is $300 for single coverage and $900 for family coverage.

The annual out-of-pocket maximum is $3,000 for individual coverage and $9,000 for family coverage. After the annual out-of-pocket maximum is met, MUSC Options will pay 100 percent of allowable charges after the applicable copayment for covered medical benefits for the remainder of the year. Annual deductibles, copayments and charges above the plan's allowed charges do not contribute to your out-of-pocket maximums. **Certain benefits such as preventive care benefits and prescription drugs are not covered out-of-network.**

## How To File Claims

When you use a network provider, you do not have to file claims. The network doctor or hospital will do it for you. If you use an out-of-network physician or hospital, you may have to file the claim yourself. You can get claim forms from your benefits office or from the Companion HealthCare Web site www.companionhealthcare.com. You will need to complete a separate claim form for each individual who received care. Mail the form to:

Companion HealthCare
MUSC Options Plan
Member Services Department
P.O. Box 6170
AX-415
Columbia, SC 29260-6170

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Member Services Department
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AX-415
Columbia, SC 29260-6170

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